Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

JAMES GARST, CHARLES MERIDIETH, DONNA LANE, and DONNA RUSSELL AMOS,

Petitioners,

v.

WAL-MART STORES, INC., SAM'S EAST, INC., and ASSOCIATES HEALTH AND WELFARE PLAN,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Is the Wal-Mart Summary Plan Description (SPD) dealing with offset of Social Security Disability Benefits in direct violation of 29 U.S.C. §§ 1022(a) and 1024(b) in that the Summary Plan Description did not expressly inform Petitioners of the Social Security Disability offset?

LIST OF PARTIES

The Petitioners are James Garst, Charles Meridieth, Donna Lane, and Donna Russell Amos. The Respondents are Wal-Mart Stores, Inc., Sam's East, Inc. and Associates Health and Welfare Plan.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
LIST OF PARTIES	ii
TABLE OF CONTENTS	iii
TABLE OF AUTHORITIES	iv
OPINION BELOW	1
STATEMENT OF JURISDICTION	2
STATUTORY PROVISIONS INVOLVED	2
STATEMENT OF THE CASE	3
REASONS WHY THE WRIT SHOULD BE GRANTED	5
I. The Court should grant the Writ to resolve the conflicts among the courts about the proper standard to be used in resolving questions under ERISA	5
II. The Court below erred in ruling that extrinsic evidence was not admissible	9
III. The Court of Appeals erred in finding that the language in the Monthly Benefit Provisions was ambiguous	10
IV. The Summary Plan Description (SPD) is misleading regarding the recoupment of retroactive Social Security Disability Benefits	13
V. Donna Lane's claim should be allowed to proceed	16
CONCLUSION	17

TABLE OF AUTHORITIES

Page

CASES

Baxter v. C.A. Muer Corp., 941 F.2d 451 (6th Cir. 1991) 16

Bidlack v. Wheelabrater Corp., 993 F.2d 603 (7th Cir. 1993) 14

Callahan v. Range Steel Co., 941 F.2d 456 (6th Cir. 1991) 8

Cooper Tire & Rubber v. St. Paul Fire & Marine Ins. Co., 48 F.3d 365 (8th Cir.), *cert. denied*, 116 S. Ct. 300 (1995) 8

Costentino v. TWR, Inc., 13 F.3d 969 (6th Cir. 1994) 16

Davis v. Kentucky Finance Cos. Retirement Plan, 887 F.2d 689 (7th Cir. 1989) 6

Doe v. Group Hospitalization & Medical Services, 3 F.3d 80 (4th Cir. 1993) 8

Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101 (1989) 5, 6, 7, 8

Hickey v. Digital Equipment Corp., 43 F.3d 941 (4th Cir. 1985) 8

Ingersoll-Rand Co. v. McClendon, 498 U.S. 132 (1990) 14

Killian v. Healthsource Provident Administrators, Inc., 153 F.3d 514 (6th Cir. 1998) 5

Patterson v. Shumate, 112 S. Ct. 2242 (1992) 14

Pitcher v. Principal Mut. Life Ins. Co., 93 F.3d 407 (7th Cir. 1996) 13, 14

TABLE OF AUTHORITIES – Continued

Page

Steffard v. Enoch Pratt Hosp., Inc. v. Travelers Insurance Co., 32 F.3d 120 (4th Cir. 1994.) 8

University Hospitals of Cleveland v. Emerson Electric Co., 202 F.3d 839 (6th Cir. 2000) 9

Wilkins v. Baptist Healthcare Sys., Inc., 150 F.3d 609 (6th Cir. 1998) 9

Yeager v. Reliance Standard Life Ins. Co., 88 F.3d 376 (6th Cir. 1996) 6

STATUTES

28 U.S.C. § 1254(1) 2

29 U.S.C. §§ 1001 *et seq.* 2

29 U.S.C. § 1002 14

29 U.S.C. § 1021 2

29 U.S.C. § 1022 ..... 2, 10, 13

S. Rep. No. 127 10

H. R. Rep. No. 533 10

OTHER AUTHORITIES

Eric Mills Holmes, 1 *Holmes Appleman on Insurance 2d* (1996) 11, 12

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The Petitioners, James Garst, Charles Meridieth, Donna Lane and Donna Russell Amos respectfully petition this Court for a Writ of Certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit holding that the district court did not err in granting summary judgment to Respondents since the Plan Administrator's (for Wal-Mart) decisions regarding a Social Security offset resulting in a substantial reduction in LTD benefits was based on a reasonable interpretation of the Plan. The Petitioners request a review of the related rulings of the lower court concerning the reasonable interpretation of the language involved and the finding that the language was not ambiguous or misleading. The Court erred in dismissing Lane's claims for failure to exhaust administrative remedies. Finally, the Court erred in refusing to consider affidavits in response to Defendants' motion for summary judgment.

OPINION BELOW

The decision of the United States Court of Appeals for the Sixth Circuit, dismissing the case is unreported. (App. 1).

STATEMENT OF JURISDICTION

The judgment of the Court of Appeals was entered on March 12, 2002. The jurisdiction of the Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.*, contains the following relevant provisions:

Part I – Reporting and Disclosure

Section 101 [29 U.S.C. § 1021] Duty of Disclosure and Reporting

(a) Summary plan description and information to be furnished to participants and beneficiaries

The Administrator of each employee benefit plan shall cause to be furnished in accordance with section 1024(b) of this title to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan –

(1) a summary plan description described in section 1022(a)(1) of this title.

Section 102 [29 U.S.C. § 1022] Plan description and summary plan description

(a)(1) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in

a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. . . .

STATEMENT OF THE CASE

During the period of explosive growth of the late 1980's and early 1990's employers expanded benefit programs in a variety of ways in order to entice, retain and reward good workers. During this time employers encouraged employees to rely on their high expectations of fringe benefits, such as Long Term Disability (LTD) for financial security after disability or retirement. These provisions benefited employers in retaining a trained work force. However, beginning in the early 1990's employers attempted to reduce costs by revising these plans, particularly these employers with self-funded plans. Unfortunately, disabled workers, who in the absence of representation of a union, became easy prey since the former employers no longer rely on their continued productivity.

In response, cases involving ERISA benefit rights are being filed by employees attempting to enforce benefit rights. Due to the multiplicity of issues in an increasing number of lawsuits, the lower courts are deeply divided in the proper analytic approach to be used in resolving these issues. In a society that is increasingly mobile – national unanimity should be a goal of this court. Employees and employers move from state to state and circuit to circuit. This case presents the questions of the proper standard used to decide how to review a plan administrator's decisions on offsetting benefits. Furthermore, this case

deals with ambiguity in the interpretation of the plan and whether extrinsic evidence – interpretative aids – should be used to assist the court in resolving the question.

Petitioners, residents of East Tennessee and former employees of Wal-Mart and Sam's Club and participants in the Plan, began their employment with Respondents in mid 1980 to 1990, purchasing LTD insurance offered by Wal-Mart. The Petitioners became disabled and filed for their LTD under the Plan. The Petitioners filed for Social Security Disability benefits. Petitioners were required to sign reimbursement agreements before they were paid LTD benefits. Petitioners with one exception (Lane) eventually qualified for SSDI benefits. Their LTD benefits were then withheld for failure to reimburse the Plan for their SSDI benefits. This ERISA action followed.

Petitioners allege a wrongful denial of LTD benefits without an offset for Social Security benefits, that they were not fully and expressly informed of their rights and obligations under the Plan, and that they did not receive notification of material modifications to the Plan or summary plan description (SPD) documents.

Petitioner Lane alleges that she did not have to exhaust her administrative remedies to maintain an action. Finally, the Petitioners sought to introduce affidavits in response to the motion for summary judgment of defendants.

The opinion by the United States Court of Appeals for the Sixth Circuit (a three judge panel of said court) affirmed the district court's granting of summary judgment to defendants. The Court in upholding the district court found that the Plan Administrator's rulings in allowing the offset of Social Security benefits was based on a

reasonable interpretation of the Plan. (App. 16-17) The Court found that the language used in the SPD read in an ordinary and popular sense meant that the only reasonable interpretation was that a participant's disability benefit under the LTD is reduced by the amount of Social Security disability a plan member receives. (App. 16-17) The Court found that Lane's dismissal or her claim for failure to exhaust her administrative remedies was proper. In conclusion, the Court also found the district court did not err in refusing to consider extrinsic evidence.

REASONS WHY THE WRIT SHOULD BE GRANTED

I. The Court should grant the Writ to resolve the conflicts among the courts about the proper standard to be used in resolving questions under ERISA.

The linchpin of the opinion of the Sixth Circuit Court of Appeals is the Standard of Review. In its opinion, it cited the leading case on the Standard of Review, *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989). Although the standard cited by the court below was somewhat correct the court failed to cite or use the appropriate and correct legal standard.

The Sixth Circuit has incorrectly adopted, "the highly deferential arbitrary and capricious standard of review" as set out in *Killian v. Healthsource Provident Administrators, Inc.*, 153 F.3d 514, 520 (6th Cir. 1998) (citing *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. at 115) when the plan administrator has interpretative discretion.

The Sixth Circuit reasons that it will uphold a benefit determination if it is "rational in light of the Plan's provisions." *Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376, 381 (6th Cir. 1996). The final analytical step is that "when it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary or capricious." *Davis v. Kentucky Finance Cos. Retirement Plan*, 887 F.2d 689, 693 (6th Cir. 1989)

The Sixth Circuit applies a misguided variant on the abuse of discretion standard. The *Firestone* decision provides a framework for review. Basically, Justice O'Connor writing for the court, opines that if the trustee has interpretative discretion, trust law generally upholds the decision as long as it is reasonable. Justice O'Connor opined:

> "Trust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers. . . . A trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee's interpretation will not be disturbed if reasonable." 489 U.S. 101, 111 (1989)

The Court goes on to say that the de novo standard is the standard to be applied unless the benefit plan gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan. However, the final factor in the court's decision deals with a situation where the administrator of the plan or fiduciary has a conflict of interest.

Justice O'Connor states in response to the issue of conflict of interest:

> "Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a *'factor* in determining whether there is an abuse of discretion.' Restatement (SECOND) of Trusts, § 187, Comment *Id.* (1959)." 489 U.S. 101, 115. (emphasis ours)

In the case at hand, Wal-Mart has an inherent self-interest since the plan is a self-funded plan. Any payments will be losses. Denials will require less money from the Wal-Mart corporation's profits. Petitioners feel that it was error for the Sixth Circuit Court of Appeals not to consider the factor of "self-interest".

Following the *Firestone Tire and Rubber Co. v. Bruch* case (489 U.S. 101 (1989)), nearly all of the circuits have modified the legal standard by which plan administrator's services are reviewed. The first determination is whether a plan administrator has interpretative discretion. If the plan administrator has interpretative discretion, the court must develop a federal common law standard to use in order to review the abuse of discretion standard. Likewise, if the Administrator does not have interpretative discretion, then the court must develop a federal common law plan interpretative rule for the *de novo* review standard of the decision.

Petitioners, after reviewing all the circuits, feel the Fourth Circuit which uses a five factor test is the most appropriate and the correct one for this case. These five factors are:

1. Are the Plan Administrator's interpretation consistent with the goals of the Plan,

2. Whether it might render some other language in the Plan meaningless or inconsistent,

3. Is the interpretation in line with the substantive requirements of ERISA,

4. Is the interpretation applied consistent, and

5. Whether it is contrary to the clear language of the Plan.

Hickey v. Digital Equipment Corp., 43 F.3d 941, 947 (4th Cir. 1985); *Steffard v. Enoch Pratt Hosp., Inc. v. Travelers Insurance Co.*, 32 F.3d 120, 126 (4th Cir. 1994).

If the interpretation is contrary to the plain meaning principle then it is an abuse of discretion. There appears to be support of this five factor test as the Eighth Circuit has also adopted this test. *Cooper Tire & Rubber v. St. Paul Fire & Marine Ins. Co.*, 48 F.3d 365, 371 (8th Cir.), *cert. denied,* 116 S. Ct. 300 (1995).

Insofar as the "abuse of discretion" standard with a conflict of interest factor – the circuits appear to pretty well comply with the Supreme Court directive in *Firestone Tire & Rubber v. Bruch*. For example, in the Fourth Circuit an Administrator with a conflict must have offered an interpretation consistent with one the court would expect from a fiduciary without a conflict. *Doe v. Group Hospitalization & Medical Services,* 3 F.3d 80, 87 (4th Cir. 1993); Accord *Hickey v. Digital Equipment Corp.*, 43 F.3d 941, 946 (4th Cir. 1995). However, the Sixth Circuit totally ignores the Supreme Court directive applying the contrary and capricious standard even in the presence of a conflict of interest. *Callahan v. Range Steel Co.*, 941 F.2d 456, 459 (6th Cir. 1991).

Petitioners feel the time has come for a material standard to review plan administrator's decisions. Wal-Mart has thousands of stores in almost every state employing thousands of people. The time is ripe for this court to intervene in the controversy, and to develop uniform rules that should be applied in cases such as this.

II. The Court below erred in ruling that extrinsic evidence was not admissible.

The court below ruled that the law is well settled that the court's review is confined to the record before the plan administrator and cited several Sixth Circuit cases. *Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 614-15 (6th Cir. 1998); also *University Hospitals of Cleveland v. Emerson Electric Co.*, 202 F.3d 839, 845 (6th Cir. 2000). Petitioners submitted an affidavit of Eric Holmes, a law professor and expert witness on contractual language. Petitioners Garst and Meridieth submitted affdiavits in support of their claim that as average plan members, they did not understand that they were subject to the Social Security Disability offset provision.

The legislative history of the ERISA regulation clearly states that the intent of Congress was to remedy the prior situations where participants could not understand the benefits they were getting or not getting:

> "It is grossly unfair to hold an employee accountable for acts which disqualify him from benefits, if he had no knowledge of these acts, or if these conditions were stated in a misleading or incomprehensible manner in plan booklets. Subcommittee findings were abundant in establishing that an average plan participant, even where he has been furnished an explanation of his plan

> provisions, often cannot comprehend them because of the technicalities and complexities of the language used.[1]

III. The Court of Appeals erred in finding that the language in the Monthly Benefit Provisions was not ambiguous.

ERISA § 29 U.S.C. § 1022(a) states that a Summary Plan Description (SPD) shall be:

> "written in a manner calculated to be understood by the average plan participant and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan."

The Sixth Circuit erred in finding the pertinent language from the 1990 version of the SPD unambiguous. The 1990 version states:

> YOUR MONTHLY BENEFITS – HOW IT IS CALCULATED?
>
> Your monthly benefit is 60% of your average monthly wage less:
>
> • all other compensation such as: pension plans, Workers' Compensation, social security retirement plans, etc."

This is the provision in the SPD which enticed or lured the employee-Petitioners in this case to sign up and

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[1] S. Rep. No. 127 at 11; H. R. Rep. No. 533 at 8, reprinted in 1974 U.S.C.C.A.N. 4639, 4646 (same).

purchase the LTD fringe benefit. The Petitioners continued to have money withheld from their paycheck to pay for the premium, a benefit which proves to be worthless. The time has come for this court to recognize the reasonable expectations for benefits through a uniform interpretative rule based on the reasonable expectation principle and the *contra proferentem* principle.

Although not all circuits apply the principal of *contra proferentem* to ERISA cases, a significant number of courts do. The principal is explained in detail in the leading commentary, Eric Mills Holmes, 1 *Holmes Appleman on Insurance 2d* 133-34 (1986) as follows:

> Since the insurer is the author ("profferor") of the document, ambiguity, doubts and equivocal words are to be construed against the insurer and resolved in the insured's favor. This bedrock insurance rule of construction ("*contra proferentum*" is also a basic contract rule as stated in the Restatement (Second) of Contracts, § 206 (1979) as follows:
>
> § 206. Interpretation Against the Draftsman
>
> In choosing among the reasonable meanings of a promise or agreement or a term thereof, that meaning is generally preferred which operates against the party who supplies the words or from whom a writing otherwise proceeds.
>
> . . . Where one party chooses the terms of a contract, he is likely to provide more carefully for the protection of his own interests than those of the other party. He is also more likely than the other party to have reason to know of uncertainties of meaning. Indeed, he may leave meaning deliberately obscure, intending to decide at a

> later date what meaning to assert. In cases of doubt, therefore, so long as other factors are not decisive, there is substantial reason for preferring the meaning of the other party. The rule is often invoked in cases of standardized contracts and in cases where the drafting party has the stronger bargaining position. . . . '

Eric Mills Holmes, 1 *Holmes Appleman on Insurance 2d* 133-34 (1996).

The end result of the ambiguous language works in favor of Wal-Mart and helps them profit. The wording in the text cited above does not do two things:

> 1. By having the plan participant file first for Social Security Disability benefits the employer ends up not having to pay the claimants from its self-insured for their LTD claims. When a plan participant wins his Social Security case Wal-Mart, in effect recoups all its money. With the thousands of stores and hundreds of thousands of employees this is another "profit" center for Wal-Mart.
>
> 2. The SPD never says in any form or fashion that once the plan participant wins his Social Security case he will have to pay "all" the back pay back to the plan.

The parties are unequal insofar as bargaining power. Wal-Mart is a big corporate giant. The plan participants have absolutely no bargaining power.

It is obvious that the provisions in the SPD given to plan participants was misleading and inaccurate. As the above language from the section "Your Monthly Benefits – How is it calculated? (1990 version) Neither provides sufficient information to make an accurate calculation nor

does it fully or fairly inform the average reader about how the actual benefits are calculated.

Typically a judge or jury interprets the language in dispute (including an insurance contract/summary plan description). Here, the construction and interpretation of the SPD in order to determine the parties' rights and duties is a matter solely for the court. Should the language in the SPD be determined to be ambiguous as a matter of law this court or a lower court, if instructed, would judicially construe the legal effect of the ambiguity.

This is further reason the writ should be granted: to correct a massive injustice to a great number of employees of the workforce in not allowing extrinsic evidence to be introduced to determine the true intent of the SPD in such cases.

IV. The Summary Plan Description (SPD) is misleading regarding the recoupment of retroactive Social Security Disability benefits.

Section 1022(a)(1) states:

> "the summary plan description . . . shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." 29 U.S.C. § 1022(a)(1) (1988).

The Courts below have an unusual analytical approach. Citing the *Pitcher* case, the lower court (district court) at Appendix (14) indicates that since the plan in this case is governed by ERISA, "we apply federal common law rules of contract interpretation in making a determination."

Pitcher v. Principal Mut. Life Ins. Co., 93 F.3d 407, 411 (7th Cir. 1996).

The courts below misapplied the standard. Somewhere in the equation should be a policy of advancing the purposes of ERISA. The ERISA of 1974 has a declaration of policy. The main purposes of this policy are to protect the interests of participants in employee benefit plans and in addition to protect interstate commerce and the federal taxing power." ERISA, 1974, § 2, 29 U.S.C. § 1002 (1988). Nowhere does it say anything about protecting employers' interests.

The United States Supreme Court often turns to the declarations of policy set out at the beginning of each piece of major legislation to interpret statutes. Often other items of case law and legislative history are used to support the Court's interpretation of laws.

Insofar as ERISA is concerned, for example, this Court has opined that one of the desired ERISA policies is to achieve national uniformity of ERISA rules. *Patterson v. Shumate*, 112 Sup. Ct. 2242, 2250 (1992) and *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 132 at 142 (1990).

The district courts need clarification and instruction from this court that it is permissible to use extrinsic evidence for interpretative purposes. Courts in other circuits allow evidence to be considered. *Bidlack v. Wheelabrater Corp.*, 993 F.2d 603, 606 (7th Cir. 1993) (en banc), the plurality opinion ordered the court to review and consider a document issued by the employer to assist in answering the question of just what promises the employer had promised.

The lower courts have indicated that the Petitioners have signed reimbursement agreements. Assuming arguendo, that they did sign the reimbursement agreement voluntarily, this argument lacks meat. There is an old saying in the region that: "that you cannot drain the swamp when you have alligators biting at your feet." The employees, and plan participants, were at that time disabled, out of work and had no income. Wal-Mart, before it hands over an LTD check forces the disabled worker to "sign here" to get the LTD benefits. The employee plan and participant would have signed anything so they would have income to buy necessities when they were disabled from working.

The same is true for the SPD booklets each plan participant supposedly received. Assuming arguendo that the booklet was received by the employee and plan participant – subtle changes in the language unaccompanied by express notice of a separate letter or other notification would be overlooked by anyone. What clearly should have been done was for Wal-Mart to somehow highlight significant changes such as this instead of making the changes unannounced.

Petitioners are not claiming that employers cannot change benefit laws, nor do petitioners say that plans can be modified, added to or even terminated. Petitioners argue that in this case the Summary Plan Description is misleading regarding both the offset and modification. Petitioners ask this Court to rule that the Summary Plan Description violates ERISA.

V. Donna Lane's claim should be allowed to proceed.

This issue is ancillary to the main issues in the case but it is important to Donna Lane. As the circuit court pointed out below, traditional exhaustion principles include an exception for the case "where resort to the administrative route is futile or the remedy inadequate." *Costentino v. TWR, Inc.*, 13 F.3d 969, 974 (6th Cir. 1994).

Petitioner feels her case should be decided under this exception. Cases of employees regarding benefits should be liberally interpreted particularly in an environment where the Social Security Disability offset in effect completely eliminates the LTD benefit. The circuit court based its decision entirely on the *Baxter* case which states "the decision whether to apply the exhaustion requirement is committed to the district court's sound discretion and should be overturned on appeal only if the district court has clearly abused its discretion." *Baxter v. C.A. Muer Corp.*, 941 F.2d 451, 453-54 (6th Cir. 1991).

Clearly, the district court, if it exercises its discretion, should have balanced the futility of continuing a claim against the doctrine of exhaustion of administrative remedies. As this is a common type of issue in the case of workers for Wal-Mart and other large national stores – it is time for the court to require a balancing test and to develop uniform rules to be applied in such cases.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted:

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June 10, 2002

NOT RECOMMENDED FOR FULL-TEXT PUBLICATION

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NOT RECOMMENDED FOR PUBLICATION

No. 00-5951

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

JAMES GARST, CHARLES MERIDIETH, DONNA LANE, and DONNA RUSSELL AMOS,

Plaintiffs-Appellants,

v.

WAL-MART STORES, INC., SAM'S EAST, INC., and ASSOCIATES HEALTH AND WELFARE PLAN,

Defendants-Appellees,

and

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY,

Defendant. /

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF TENNESSEE

(Filed March 12, 2002)

BEFORE: NORRIS and CLAY, Circuit Judges; SARGUS, District Judge.*

CLAY, Circuit Judge. Plaintiffs James Garst, Charles Meridieth, Donna Lane, and Donna Russell Amos appeal from the district court's order granting summary judgment in favor of Defendants Wal-Mart Stores, Inc. ("Wal-Mart"), Sam's East, Inc., ("Sam's Club"), a wholly owned subsidiary of Wal-Mart, Associates' Health and Welfare Plan and Hartford Life and Accident Insurance Company ("Hartford") in an action brought under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. Plaintiffs filed suit seeking long-term disability ("LTD") benefits without any offset for Social Security benefits under Associates' Health and Welfare Plan ("the Plan"), a self-funded employee welfare benefit plan sponsored by Wal-Mart and administered by Hartford. For the reasons set forth below, we **AFFIRM** the district court's judgment.

BACKGROUND

Plaintiffs, former employees of Wal-Mart and Sam's Club and participants in the Plan, began working for Wal-Mart or Sam's Club from the mid-1980s to 1990, purchasing LTD insurance offered by Wal-Mart through Hartford. Subsequently, Plaintiffs became disabled and submitted claims for LTD insurance in 1994 and thereafter. Before Plaintiffs were paid the LTD benefits, they each signed reimbursement agreements obligating them to repay

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* The Honorable Edmund A. Sargus, Jr., United States District Judge for the Southern District of Ohio, sitting by designation.

Hartford, the insurance carrier of the Wal-Mart plan, for "all other income benefits," including Social Security Disability Insurance ("SSDI") benefits and retirement benefits. Plaintiffs, with the exception of Lane, eventually qualified for SSDI benefits. Hartford withheld their LTD benefits when Plaintiffs, except for Lane, failed to repay the Plan for their SSDI benefits. Consequently, Plaintiffs, individually and as named members of a proposed class, brought this ERISA action.

In their original complaint, Plaintiffs primarily alleged that they were wrongfully denied LTD benefits without an offset for Social Security benefits, that they were not informed of their rights and obligations under the Plan, and that they did not receive notification of material modifications to the Plan or the summary plan description ("SPD") documents. After Defendants filed motions for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure on January 6, 2000, Plaintiffs moved to amend their original complaint to allege the ERISA violations with specificity. The district court granted Plaintiffs' motion to amend on June 9, 2000, addressing Defendants' respective motions for summary judgment in the context of Plaintiffs' amended complaint. In an order issued on June 9, 2000, the district court granted Defendants' respective motions for summary judgment based on the reasons set forth in its memorandum opinion. Plaintiffs filed a timely appeal on July 10, 2000, challenging the grant of summary judgment in favor of Defendants Wal-Mart, Sam's Club and Associates Health and Welfare Plan. On November 17, 2000, this Court granted Plaintiffs' motion to dismiss the appeal against Hartford, the plan administrator.

DISCUSSION

Standard of Review

This Court reviews *de novo* a district court's grant of summary judgment in an ERISA action. Summary judgment is appropriate where "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law" FED. R. CIV. P. 56(c). *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986); *Booker v. Brown & Williamson Tobacco Co., Inc.*, 879 F.2d 1304, 1310 (6th Cir. 1989).

In evaluating an administrator's or fiduciary's interpretation of an ERISA-governed plan, the district court applies a *de novo* standard unless the plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). If the plan gives such discretionary authority, this Court reviews the administrator's decision to deny benefits using "the highly deferential arbitrary and capricious standard of review." *Killian v. Healthsource Provident Administrators, Inc.*, 152 F.3d 514, 520 (6th Cir. 1998) (citing *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. at 115).

In the case at bar, the Plan designated Hartford as its claims administrator, giving Hartford discretionary authority to resolve all questions concerning the administration, interpretation or application of the Plan. Thus, this Court reviews the district court's grant of summary judgment to "'determine if there is any genuine issue of material fact whether the insurance company's decision to

deny benefits was arbitrary or capricious.'" *Killian*, 152 F.3d at 520 (quoting from *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 986 (6th Cir. 1991)). Under this deferential "arbitrary or capricious" standard, this Court will uphold a benefit determination if it is "rational in light of the plan's provisions." *Yeager v. Reliance Standard Life Ins. Co.*, 88 F.3d 376, 381 (6th Cir.1996) (internal quotations and citation omitted). Therefore, "[w]hen it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary or capricious." *Davis v. Kentucky Finance Cos. Retirement Plan*, 887 F.2d 689, 693 (6th Cir.1989) (citation omitted).

Analysis

On appeal, Plaintiffs assert that the Plan as written is in direct violation of 29 U.S.C. § 1022(a) and § 1024(b) because the SPD did not expressly inform them that they were required to apply for SSDI benefits and that they would be required to reimburse Hartford for any retroactive payment of SSDI benefits that they received, and because they did not understand that the Plan included a provision for the SSDI offset. Plaintiffs also claim that they did not receive copies of subsequent modifications of the SPD containing the provisions at issue. (Plaintiffs' Br. at 22-23). In this case, the district court did not err in granting summary judgment to Defendants because the Plan Administrator's decisions requiring Plaintiffs to apply for SSDI benefits and reducing LTD benefits by any SSDI benefits that they received were based upon a reasonable interpretation of the Plan.

The Monthly Benefit provision in the SPD is not ambiguous.

29 U.S.C. § 1022(a) provides in pertinent part that a SPD be "written in a manner calculated to be understood by the average plan participant and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." In this case, the pertinent provision in the January 1990 version of the SPD provides:

> YOUR MONTHLY BENEFIT – HOW IT IS CALCULATED?
>
> Your monthly benefit is 60% of your average monthly wage less:
>
> • all other compensation such as: pension plans, Workers' Compensation, social security retirement plans, etc.

However, the provision was subsequently modified, appearing in the 1994 and 1996 versions of the SPD as follows:

> YOUR MONTHLY BENEFIT – HOW IT IS CALCULATED?
>
> Your monthly benefit is 60% of your average monthly wage less:
>
> • All other income benefits such as Workers' Compensation and Social Security Benefits to which you and your dependents may be entitled because of your disability or retirement and lost wages from a "no fault" automobile insurance plan.

Federal common law principles of contract interpretation are used in construing language of a plan governed by

ERISA. *Perez v. Aetna Life Ins. Co.*, 150 F.3d 550, 556 (6th Cir.1998). Plan provisions are to be interpreted according to their plain meaning, in an ordinary and popular sense. *Id.* "In applying this plain meaning analysis, we 'must give effect to the unambiguous terms of an ERISA plan.'" *Id.* (quoting from *Lake v. Metropolitan Life Ins. Co.*, 73 F.3d 1372, 1379 (6th Cir. 1996)).

As Defendants point out, the Plan is subject to amendment by the Administrative Committee at any time without the consent of the participants. *See Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) ("Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans."); *Sengpiel v. B.F. Goodrich Co.*, 156 F.3d 660, 666 (6th Cir. 1998) (holding that welfare plans may reduce, amend or terminate benefits at any time).[1] Since all Plaintiffs sought LTD benefits after the 1994 version of the SPD was in effect, it follows that our inquiry is directed to the 1994 and 1996 versions of the provision in question. Here, the Plan terms in question for the years 1994 through 1997 are identical. Reading the contractual language of the provision in question in an ordinary and popular sense, the only reasonable interpretation of this

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[1] ERISA defines "welfare benefit plan" as follows:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability. . . .

29 U.S.C. § 1002(1)(1988).

language is that a participant's disability benefit is reduced by the amount of any Social Security benefit received by the participant.[2]

In addition, there is nothing in the record to support Plaintiffs' assertion that they did not receive the SPD booklets modifying the terms of the coverage for each year in which they were enrolled in the Plan. Defendants claim that Plaintiffs received the SPD booklets, specifically the enrollment form for 1994, which contained the following language: "I understand the Personal Choice program as described in the enrollment materials." (Defendants' Br. at 26-27). The 1996 and 1997 enrollment forms contained similar language: "I have received a copy of the Wal-Mart Benefits Book and I understand my benefits programs as described in the book and enrollment materials."

Even assuming *arguendo* that Plaintiffs did not receive the SPD booklets, they still cannot show that they are entitled to a substantive remedy under § 1024. Under § 1024(b)(4) the following is provided:

> [T]he administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement,

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[2] In the district court, Plaintiffs contended that the language of the earlier 1990 version was ambiguous and not "calculated to be understood by the average plan participant." Even if the language of the 1990 provision is deemed to be ambiguous on the ground that it may be reasonably interpreted to mean that monthly LTD benefits, while offset by Social Security retirement benefits, are not offset by SSDI benefits, it is clear that the change in the policy language beginning in 1994 to include "Social Security Benefits" does not present any such ambiguity.

> contract, or other instrument under which the plan is established or operated.

29 U.S.C. 1024(b)(4). A violation of this section subjects a plan administrator to a potential penalty under § 502(c) of ERISA, which grants a reviewing court the discretion to impose a penalty of up to $100 a day on a plan administrator – payable to the participant or beneficiary who submitted a written request to the administrator – when it finds that the administrator "fail[ed] or refuse[d] to comply with a request for any information which such administrator [was] required by this subchapter to furnish . . . unless such failure or refusal result[ed] from matters reasonably beyond the control of the administrator. . . . " 29 U.S.C. § 1132(c). The purpose of ERISA's penalty provision is "not so much to penalize as to induce plan administrators to respond in a timely manner to a participant's request for information." *Winchester v. Pension Comm. of Michael Reese Health Plan, Inc.*, 942 F.2d 1190, 1193 (7th Cir.1991). Thus, any presumed violation of § 1024 does not give rise to a substantive remedy in this case.

The Social Security Benefit provision in the SPD is not ambiguous.

Plaintiffs also assert that the SPD was not "written in a manner calculated to be understood by the average plan participant" under 29 U.S.C. § 1022 because "[they], as average plan participants, did not understand that they were required to apply for SSDI benefits before they could apply for LTD benefits, nor did they understand it to require them to reimburse the defendant for any retroactive payment received as a result of applying for SSDI

benefits." (Plaintiffs' Br. at 23). There is no merit to these assertions.

As Defendants point out, the SPD contains the following provision:

> SOCIAL SECURITY BENEFIT –
> WHY SHOULD I FILE?
> If your disability is expected to last or has lasted five consecutive months, you are required to apply for Social Security disability benefits. If you are denied such benefits, you will be required to follow the appeal process through to a hearing before an administrative law judge if necessary.

Reading the contractual language of this provision in an ordinary and popular sense, the only reasonable interpretation of this language is that a participant was required to apply for SSDI benefits. Contrary to Plaintiffs' assertion, the language contained in the SPD does expressly state that they were required to apply for SSDI benefits before they could receive LTD benefits. In addition, each Plaintiff signed and submitted an LTD Payment Options and Reimbursement Agreement containing the following language:

> The benefit plan under which you are covered provides that Long Term Disability (LTD) benefits will be reduced by the amount of Other Income Benefits which you are eligible to receive. Please refer to your Plan Booklet for a full description of Other Income Benefits.

The form explicitly defined "Other Income Benefits" as "Social Security Disability/Retirement."

Moreover, as the district court noted, Plaintiffs were approved for LTD benefits under the Plan, and all elected

to receive the full amount provided by the policy, while acknowledging in writing the following provision:

> B. Please pay me my monthly Long Term Disability benefit with no reduction for estimated Other Income Benefits. I understand that this may result in an overpayment of my LTD benefits which I will be required to refund to the Benefit Plan in a lump sum.

In short, the contractual language of the Social Security provision in the SPD was not ambiguous, allowing for only one reasonable interpretation requiring a participant to apply for SSDI benefits and reducing LTD benefits by any Social Security benefits that the participant received.

Although Plaintiffs argue that they did not understand that the provision required an offset of their SSDI benefits, Defendants correctly point out that ERISA does not impose a duty upon the plan fiduciary to explain the meaning and significance of the SSDI offset, "[a]bsent a specific employee-initiated inquiry." *Electro-Mechanical Corp. v. Ogan*, 9 F.3d 445, 451-52 (6th Cir. 1993). Further, while Plaintiffs allege that they did not understand that they were required to apply for SSDI benefits, it so happens that each Plaintiff applied for such benefits. Notwithstanding, there is no indication that Plaintiffs questioned the Plan Administrator about the application of the provision offsetting SSDI benefits. Accordingly, Defendants did not have the duty to explain the terms of the Plan to Plaintiffs. *Id.*

The SPD was not misleading regarding the recoupment of retroactive SSDI payments.

Nevertheless, Plaintiffs claim that the district court erred in finding that the SSDI offset was valid because "the disability offset is in violation of ERISA as it applies to them because the summary plan description on which they relied when purchasing the LTD was misleading because it omitted the SSDI offset, reimbursement requirements and prerequisite applications for SSDI." (Plaintiffs' Br. at 17.) Contrary to Plaintiffs' assertion, there was no ambiguity created in the SPD just because the SPD did not state that "they would be required to reimburse the defendants for any lump sum retroactive SSDI payment received by the plaintiffs. . . . " (Plaintiffs' Br. at 21.) Even though the SPD did not expressly state that there was a right under the Plan to recoup overpayments, it is clear that retroactive recoupment was contemplated by the Plan. *See Lake v. Metropolitan Life Ins. Co.*, 73 F.3d 1372, 1377-78 (6th Cir. 1996) (finding that even though the Plan's language did not specifically distinguish between retroactive and prospective SSDI payments, language providing that payments would be "reduced by . . . any primary Social Security benefits" entitled the Plan to reduce LTD benefits by any SSDI payments and to recoup retroactive SSDI awards).

Further, contrary to Plaintiffs' claim, the fact that they did not receive a copy of the underlying Plan does not distinguish this case from *Lake* where the plaintiffs received a copy of the underlying plan and the SPD as a single package. In support, Plaintiffs rely upon *Edwards v. State Farm Mut. Auto. Ins. Co.*, 851 F.2d 134 (6th Cir. 1988), where this Court enforced the terms of the SPD whose terms directly contradicted those found in the

underlying plan and where the plaintiff had received only the SPD. Such reliance on *Edwards* is completely misplaced. As Defendants correctly point out, there is nothing to indicate that there is a conflict between the terms of the SPD and those of the underlying Plan in this case.

There is also no support for Plaintiffs' reliance upon *Bush v. Metropolitan Life Ins. Co.*, 656 F.2d 231, 233 (6th Cir. 1981) for the proposition that reimbursement will not be enforced when the SPD does not mention the reimbursement of Social Security benefits and such reimbursement results in a hardship to the participant. In *Bush*, this Court held that the terms of the plan providing for insurance coverage did not permit the defendant to recoup a retroactive lump-sum SSDI award. As discussed in *Lake*:

> The linchpin of the court's decision [in *Bush*] was the existence of ambiguity in the recoupment provision. The court noted that the phrase "should have not been paid or should have been paid in a lesser amount" was subject to two equally plausible interpretations: (a) an overpayment is determined by all facts whenever occurring, or (b) an overpayment is determined solely by facts in existence at the time of the payment. The *Bush* court then applied the Michigan state law doctrine of contra proferentum against the defendant to prohibit recoupment in cases involving a retroactive award of SSDI benefits.

Lake, 73 F.3d at 1378. Thus, *Lake* is controlling on the issue concerning the SPD provision regarding the recoupment of retroactive SSDI payments.

Plaintiff Lane failed to exhausted her administrative remedies.

The district court also did not err in granting summary judgment with regard to Plaintiff Lane for failure to exhaust her administrative remedies. "[T]he decision whether to apply the exhaustion requirement is committed to the district court's sound discretion and can be overturned on appeal only if the district court has clearly abused its discretion." *Baxter v. C.A. Muer Corp.*, 941 F.2d 451, 453-54 (6th Cir. 1991). Traditional exhaustion principles include an exception for instances "when resort to the administrative route is futile or the remedy inadequate." *Costantino v. TRW, Inc.*, 13 F.3d 969, 974 (6th Cir. 1994). Exhaustion of administrative remedies is a prerequisite to commencing suit under ERISA to recover benefits alleged to be due under an employee welfare benefit plan. *Baxter*, 941 F.2d at 453 (requiring the exhaustion of administrative remedies of denial of medical benefits before filing a federal suit). "The fact that permissive language was used in framing the administrative review provision makes no difference." *Id.* at 454 (citation omitted).

In this case, Lane's benefits were terminated on November 1, 1997 because she was no longer disabled under the terms of the Plan after her physician released her to perform unrestricted work. Slightly more than one year after her benefits were terminated, Lane, through her counsel, wrote a letter dated November 5, 1998 concerning the denial of her LTD benefits. On December 16, 1998, Hartford informed Lane's counsel that it needed a signed authorization from Lane authorizing release of her file. Although Lane wrote to Hartford on February 4, 1999, requesting an explanation of the dismissal of her LTD benefits and to have the information sent to her attorney,

she did not pursue the matter after Hartford transmitted the requested information to Lane's attorney, stating that her benefits were terminated because she "no longer meets definition of disability." Lane alleged that pursuing her administrative claim was futile since "a successful claim would result in benefits of only a few dollars a month" in light of the provision offsetting SSDI benefits.

Here, Lane failed to exhaust her administrative remedies once she was informed that her LTD benefits were terminated because she was no longer disabled under the Plan. Further, as Defendants point out, under the terms of the Plan, Lane had 60 days within which to appeal the decision denying benefits. Thus, even if Lane had pursued the matter administratively, her claim was not subject to judicial review because she failed to comply with a reasonable time constraint imposed by the plan for administrative review of denial of her claim. *See Moffitt v. Whittle Communications, L.P.*, 895 F. Supp. 961, 969 (E.D. Tenn. 1995) (finding that insurer did not waive plan provision requiring request for administrative review within 60 days and was not estopped from relying on provision). Accordingly, the district court's grant of summary judgment in favor of Defendants with respect to Lane was proper.

The district court properly refused to consider evidence outside the administrative record.

Finally, the district court properly did not consider affidavits that Plaintiffs filed in response to Defendants' motions for summary judgment because they were not available to the Plan Administrator. It is well-settled that this Court's review is confined to the record that was

before the plan administrator. *See Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 614-15 (6th Cir. 1998); *see also University Hospitals of Cleveland v. Emerson Electric Co.*, 202 F.3d 839, 845 (6th Cir. 2000) ("[I]n our review of the District Court's ruling, we will consider only the materials available to the EBC, and not any depositions, affidavits, or similar litigation-related materials that the parties submitted to the District Court.") In this case, Plaintiffs submitted the affidavit of Eric Holmes, a law professor, and those of Plaintiffs Garst and Meridieth, in support of their claim that, as average plan participants, they could not understand that the SPD required them to apply for SSDI benefits before they could receive LTD benefits, or that they were required to pay reimbursement for retroactive SSDI benefits. (Plaintiffs' Br. at 15-16). Because the affidavits were not available to the Plan Administrator when it made the decision to enforce the Social Security offset, they were properly excluded from consideration. *Wilkins*, 150 F.3d at 614-15. In any event, as we have already concluded, Hartford's interpretation of the Plan's provisions was reasonable.

CONCLUSION

The district court did not err in granting summary judgment to Defendants because the Plan Administrator's decisions requiring Plaintiffs to apply for SSDI benefits and reducing LTD benefits by any SSDI benefits that they received were based upon a reasonable interpretation of the Plan. First, reading the contractual language of the Monthly Benefit provision in the SPD in an ordinary and popular sense, the only reasonable interpretation of this language is that a participant's disability benefit is reduced by the amount of any Social Security benefit received by the

participant. Second, the contractual language of the Social Security provision in the SPD was not ambiguous, allowing for only one reasonable interpretation requiring a participant to apply for SSDI benefits and reducing LTD benefits by any Social Security benefits that the participant received. Third, the SPD was not misleading regarding the recoupment of retroactive SSDI payments. Further, the district court properly granted summary judgment to Defendants and dismissed Lane's claim for failure to exhaust her administrative remedies. Finally, the district court did not err in refusing to consider affidavits that Plaintiffs filed in response to Defendants' motion for summary judgment because they were not available to the Plan Administrator. Accordingly, we **AFFIRM** the district court's judgment.

UNITED STATES DISTRICT COURT FOR THE
EASTERN DISTRICT OF TENNESSEE
AT GREENEVILLE

JAMES GARST, ET. AL.	) NO. 2:99-CV-273
v.	)
WAL-MART, ET. AL.	) (Filed June 9, 2000)

MEMORANDUM

This ERISA matter is before the Court to consider motions for summary judgment filed by the defendants. The plaintiffs were all employed by the defendants Wal-Mart Stores, Inc. d/b/a Sam's East Inc. The plaintiffs all applied for and received long-term disability coverage under a plan offered by the defendant ITT Hartford. The plaintiffs contend that the defendants have impermissibly taken an offset of their Social Security Benefits from their long-term disability benefits. Plaintiffs have filed a motion to amend their complaint to plead with more specificity the ERISA violations that they contend occurred in this case. This motion to amend is GRANTED, [Doc. 15], and the Court will address the defendants' motions for summary judgment in the context of plaintiffs' amended complaint.

The specific provision of the plan summary that the plaintiffs contend is ambiguous and not "calculated to be understood by the average plan participant" is contained in the 1990 plan summary which reads as follows:

> MONTHLY BENEFIT – HOW IT IS CALCULATED
>
> Your monthly benefit is 60% of your average monthly wage less:

> – all other income benefits such as: pension plans, Workers' Compensation, social security, retirement plans, etc.
>
> – 50% of income from Rehabilitative employment, and
>
> – all other income from any employment or for any work.
>
> 1990 Wal-Mart Benefits SPD, p. E-4.

According to the complaint, all four plaintiffs were approved for long-term disability under the plan provided by their employer, Walmart Stores, Inc., d/b/a Sam's Club East, and elected to receive the full amount provided for in the policy, while acknowledging in writing as follows:

> B. Please pay me my monthly Long Term Disability benefit with no reduction for estimated Other Income Benefits. I understand that this may result in an overpayment of my LTD benefits which I will be required to refund to the Benefit Plan in a lump sum.

This form also specifically defined "Other Income Benefits" as Social Security Disability/Retirement.

I. ADDITIONAL EVIDENCE

As an initial matter, the Court notes that the plaintiffs have filed affidavits in support of their response to the defendants' motions for summary judgment. However, it is clearly settled that this Court's review is confined to the record that was before the plan administrator.

As explained by the court in *Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 614-615 (6th Cir.1998):

> Wilkins asserts that the district court erred in failing to consider an affidavit of Dr. Vanarthos, describing his impressions of the February 11, 1994 MRI. This argument is meritless. Although the district court reviewed the decision of the Plan Administrator de novo, the district court was confined to the record that was before the Plan Administrator. See *Perry v. Simplicity Engineering*, 900 F.2d 963, 966 (6th Cir. 1990); see also *Rowan*, 119 F.3d at 437. LINA made its final decision denying Wilkins's claim for benefits on May 4, 1995. The Vanarthos affidavit is dated June 20, 1995. Therefore, the affidavit was not included in the record upon which LINA based its decision; accordingly, it also was not part of the district court's consideration of Wilkins's claim. We thus conclude that the district court did not err in excluding from its review of Wilkins's claim evidence that was not part of the administrative record.

The Sixth Circuit in *University Hospitals of Cleveland v. Emerson Electric Company*, 202 F.3d 839, 845 (6th Cir. 2000), has also held:

> Likewise, in our review of the District Court's ruling, we will consider only the materials available to the EBC, and not any depositions, affidavits, or similar litigation-related materials that the parties submitted to the District Court.

Therefore, this Court will consider only the materials available to the plan administrator, and not any affidavits, or similar litigation-related materials, that the plaintiffs have submitted to this Court.

II. SPECIFIC UNDISPUTED FACTS CONTAINED IN THE ADMINISTRATIVE RECORD

A. James Garst

1. On September 28, 1988, James Garst ("Garst") began employment with Sam's Club East. Garst voluntarily enrolled in and obtained long-term disability coverage under the policy, effective January 1, 1990.

2. On December 7, 1995, Garst ceased work due to cervical spondylosis, spinal canal stenosis, and myelopathy. Garst subsequently applied for long-term disability benefits on April 9, 1996, the application for which Hartford received on April 16, 1996. In connection with his application, Garst signed and submitted an Other Income Questionnaire and a Claim questionnaire on April 9, 1996, in which he certified that he was receiving no "other income benefits," but that he had applied for Social Security and was in the process of appealing the initial denial of same. Garst also signed and submitted an LTD Payment Options and Reimbursement Agreement, in which he acknowledged that, pursuant to the Plan, LTD benefits were to be reduced by the amount of any "other income benefits" he would receive in the future, and in particular, Social Security disability/retirement benefits. Finally, Garst elected to receive LTD benefits with no reduction for estimated "other income benefits" and agreed to refund any overpayment resulting from the election in a lump sum to Hartford.

3. On June 3, 1996, Garst's LTD claim was approved with benefits payable at a monthly rate of $977.75. Garst began receiving monthly benefits with no offsets on or about June 6, 1996, his benefit effective date.

4. On June 19, 1997, Garst's claim for Social Security disability benefits was approved in full with benefits to be paid retroactive to December 6, 1995. As a result of the retroactive Social Security award, an overpayment of LTD benefits was incurred by Garst in the amount of $8,201.95.

5. On May 26, 1998, Hartford notified Garst of the overpayment and advised that, pursuant to the offset provisions in the Plan and the LTD Payment Options and Reimbursement Agreement, monthly long-term disability benefits would be withheld until such time as the overpayment was repaid in full. Since that date, Hartford has had several communications with Garst regarding the overpayment. To date, Hartford has not received reimbursement from Garst and thus, Hartford continues to withhold Garst's monthly LTD benefits to recoup the overpayment.

B. Charles Meridieth

6. Charles Meridieth ("Meridieth") began employment at Sam's Club East on July 10, 1985. Mr. Meridieth applied for and obtained long-term disability insurance coverage under the policy, effective, January 1, 1990.

7. On or about March 14, 1997, Meridieth ceased working as a result of severe cellulitis of the foot and leg. Meridieth submitted his application for long-term disability benefits on or about September 5, 1997.

8. In addition to his application, Meridieth signed and submitted an LTD Payment Options and Reimbursement Agreement on September 5, 1997, in

which he acknowledged that, pursuant to the Plan, LTD benefits were to be reduced by the amount of any "other income benefits" he would receive in the future, and in particular, Social Security disability/retirement benefits. Meridieth further elected to receive LTD benefits with no reduction for estimated "other income benefits," and agreed to refund any overpayment resulting from the election in a lump sum to Hartford. On September 16, 1997, Meridieth's LTD claim was approved, with monthly benefits in the amount of $1,096.29 to begin on September 27, 1997.

9. On November 10, 1997, Meridieth's initial claim for Social Security disability benefits was denied. As required by the terms of the policy, Meridieth appealed the Social Security Administration's decision.

10. On or about June 9, 1998, Meridieth advised Hartford that his Social Security claim had been approved effective September 1997, in the amount of $931 a month. As a result of the lump sum retroactive Social Security award, an overpayment of LTD benefits was incurred by Meridieth in the amount of $6,927.50. Accordingly, pursuant to the Plan terms and LTD Payment Options and Reimbursement Agreement, Hartford began to withhold Meridieth's monthly disability benefits in order to recoup the overpayment.

C. Donna Russell

11. Donna Russell ("Russell") began employment with Sam's Club East on April 10, 1990. Russell applied for and obtained long-term disability insurance coverage under the policy, effective August 30, 1991. On or about

February 15, 1994, Russell ceased work due to auto immune chronic hepatitis.

12. On July 6, 1994, Russell submitted a claim for long-term disability benefits, which was received by Hartford on July 12, 1994. In connection with her application, Russell signed and submitted an Other Income Questionnaire on July 6, 1994, wherein she certified that she was receiving no "other income benefits." Russell also submitted an LTD Payment Options and Reimbursement Agreement, in which she acknowledged that, pursuant to the plan, LTD benefits were to be reduced by the amount of any "other income benefits" she would receive in the future, and in particular, Social Security disability retirement benefits. Finally, Russell elected to receive LTD benefits with no reduction for estimated "other income benefits," and agreed to refund any overpayment resulting therefrom in a lump sum to Hartford.

13. On August 24, 1994, Russell's disability claim was approved, with monthly benefits in the amount of $563.45 to begin on September 1, 1994. On or about September 12, 1994, Russell advised Hartford that she had been approved for Social Security disability benefits and dependent Social Security benefits, in an amount in excess of her monthly LTD benefits. As a result of Russell's Social Security award, Russell received an overpayment of LTD benefits in the amount of $563.45.

14. Russell acknowledged the overpayment owed and made a partial payment in the amount of $153.00 on September 13, 1994. However, on March 20, 1995, Russell advised Hartford that she was unable to reimburse Hartford for the remainder of the overpayment due ($410.45) at

that time, but that she would do so when she returned to work.

15. On April 5, 1995, in accordance with the terms and conditions of the policy, Hartford requested that Russell provide an updated attending physician's statement certifying that she remained totally disabled. Hartford received no reply to its request or to its subsequent requests of May 25, June 8, June 27, and July 21, 1995.

16. On August 18, 1995, Hartford sent a final letter to Russell requesting proof of continuous total disability, and advising that if it was not received, Russell's claim would be terminated. Russell failed to respond to Hartford's final request, and thus, on September 18, 1995, her claim was terminated for failure to furnish proof of continuous total disability, retroactive to April 1, 1995.

17. On March 26, 1999, some three and a half years after the termination of Russell's claim, Wal-Mart received a letter, in which Russell demanded that all past benefits be paid with interest. On April 12, 1999, Hartford informed Russell of the basis of its original denial, and advised that in order to re-evaluate her claim, she would need to submit an updated attending physician's statement certifying her continuous total disability. Additionally, Hartford reminded Russell of the overpayment in the amount of $410.45 still due.

D. Donna Lane

18. Donna Lane ("Lane") began employment with Sam's Club East on or about August 8, 1987. Lane applied for and obtained long-term disability insurance coverage under the policy, effective January 1, 1992.

19. On October 1, 1996, Lane ceased work due to a femoral fracture. Lane subsequently submitted a claim for long-term disability benefits on April 2, 1997, which Hartford received on April 12, 1997. As with the other plaintiffs, Lane signed and submitted an LTD Payment Options and Reimbursement Agreement dated April 2, 1997, in which she acknowledged that, pursuant to the Plan, LTD benefits were to be reduced by the amount of any "other income benefits" she would receive in the future, and in particular, Social Security disability/retirement benefits. Lane elected to receive LTD benefits with no reduction for estimated "other income benefits," and agreed to refund any overpayment resulting therefrom in a lump sum to Hartford.

20. On May 16, 1997, Lane's claim for LTD benefits was approved, with a monthly benefit in the amount of $864.24 to be payable effective April 15, 1997. On or about September 26, 1997, Lane's claim for Social Security disability benefits was denied.

21. On September 17, 1997, in order to evaluate Lane's eligibility for continuing disability benefits, Hartford requested that Lane provide an updated Attending Physicians Statement certifying Lane's continuous total disability.

22. On October 17, 1997, Hartford received the Attending Physician Statement from Dr. Testerman, Lane's treating physician, in which Dr. Testerman certified that Lane could return to unrestricted work on November 1, 1997. Consequently, on October 27, 1997, Hartford advised Lane that her LTD benefits would be terminated effective November 1, 1997. In accordance with

the Plan terms, Lane's benefits were terminated on November 1, 1997.

III. BREACH OF FIDUCIARY DUTY

To the extent that the plaintiffs allege a breach of a fiduciary duty by the defendants, the Court notes that the plaintiffs cannot maintain their claim to recover benefits as well as a claim for breach of a fiduciary duty. As explained by the Court in *Kennedy v. United Healthcare of Ohio, Inc.*, 186 F.R.D. 364, 367-368 (S.D. Ohio 1999), citing *Varity Corp. V. Howe*, 516 U.S. 489 (1996):

> United Healthcare also contends that Plaintiffs cannot maintain their claim for breach of fiduciary duty and demand for accounting under § 1132(a)(3) while simultaneously sustaining a claim to recover benefits or enforce the terms of the plan pursuant to § 1132(a)(1)(B). In *Varity*, the Supreme Court limited the relief afforded by § 1132(a)(3) to participants or beneficiaries who may not avail themselves of other remedies under § 1132. See *Varity*, 516 U.S. at 512, 116 S. Ct. 1065. The Supreme Court interpreted § 1132 to authorize claims for breach of fiduciary duty pursuant to § 1132(a)(3) *only* where an adequate remedy was not available under another subsection of § 1132. See Id. In *Varity*, beneficiaries were permitted to pursue claims under § 1132(a)(3) only because no other remedy was available to them under § 1132. [FN1] But that is not the case here. Plaintiffs can and have pursued relief to recover benefits allegedly due under the terms of the plan and to enforce their rights under the plan pursuant to § 1132(a)(1)(B). Thus, because Plaintiffs can avail themselves of other remedies afforded by § 1132, under *Varity*, they cannot

> also maintain breach of fiduciary duty claims under § 1132(a)(3). (emphasis added).

Therefore, because the plaintiffs have pursued relief to recover benefits allegedly due under the terms of the plan and to enforce their rights under the plan pursuant to § 1132(a)(1)(B), under *Varity*, they cannot also maintain breach of fiduciary duty claims under § 1132(a)(3). Accordingly, plaintiffs' claims in regard to a breach of fiduciary duty will be dismissed.

IV. COMMON LAW CLAIMS

The Sixth Circuit addresses the wide variety of common law claims that are preempted by ERISA in *Smith v. Provident Bank*, 170 F.3d 609, 615 (6th Cir.1999):

> Stauter has asserted common law claims against Provident for conversion, negligence, trover, replevin, destruction of evidence, misrepresentation, and bad faith. All of these except bad faith are also asserted against Cambron. The claims for negligence, trover, and replevin are also asserted against Cowen, the Rossmans, Star, and the Diocese.
>
> Their claims merely attach new, state-law labels to the ERISA claims for breach of fiduciary duty and recovery of benefits, for the apparent purpose of obtaining remedies that Congress has chosen not to make available under ERISA. "It is not the label placed on a state law claim that determines whether it is preempted, but whether in essence such a claim is for the recovery of an ERISA plan benefit." *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1276 (6th Cir.1991), cert. dismissed, 505 U.S. 1233, 113 S. Ct. 2, 120 L.Ed.2d 931 (1992). Stauter's remedy

> against the Plan fiduciaries lies with ERISA, and substitute common law claims are preempted. See *Tolton*, 48 F.3d at 941-43 (holding that ERISA preempted beneficiary's state-law claims against plan, including wrongful death, malpractice, insurance bad faith, and breach of contract); *Kramer*, 80 F.3d at 1083 (holding that ERISA preempted beneficiary's state-law claims against ERISA fiduciary for fraud, negligence, securities violations, and breach of contract).

In this case, the Court finds that the plaintiffs' state law claims are in essence a claim for the recovery of an ERISA plan benefit, and therefore, plaintiffs' state law claims alleging a fraudulent scheme, a "bait and switch" scheme, and various misrepresentations are preempted, and will be dismissed.

V. CONCLUSIONS OF LAW REGARDING OFFSET

The Sixth Circuit has specifically held that a disability benefit plan that offsets Social Security disability and retirement benefits does not violate the Employee Retirement Income Security Act (ERISA). *Lake v. Metropolitan Life Ins. Co.*, 73 F.3d 1372 (6th Cir. 1996).

Guidelines for the interpretation of an ERISA plan is explained by the Sixth Circuit in *Perez*, 150 F.3d at 556-557:

> Because the Plan is governed by ERISA, we apply federal common law rules of contract interpretation in making our determination. *Pitcher v. Principal Mut. Life Ins. Co.*, 93 F.3d 407, 411 (7th Cir.1996). In developing federal common law rules of contract interpretation, we take direction from both state law and general contract law

> principles. *Regents of the Univ. of Michigan v. Agency Rent-A-Car*, 122 F.3d 336, 339 (6th Cir.1997). The general principles of contract law dictate that we interpret the Plan's provisions according to their plain meaning, in an ordinary and popular sense. *Id.* Other circuits agree with this plain meaning approach to interpretation of ERISA contract provisions. *Pitcher*, 93 F.3d at 411 (interpreting ERISA-regulated policy "' [i]n an ordinary and popular sense as would a person of average intelligence and experience. . . . '") (quoting *Meredith v. Allsteel, Inc.*, 11 F.3d 1354, 1358 (7th Cir.1993)); *Bartlett v. Martin Marietta Operations Support, Inc. Life Ins. Plan*, 38 F.3d 514, 517 (10th Cir.1994) (applying plain meaning analysis); *Hughes v. Boston Mut. Life Ins. Co.*, 26 F.3d 264, 268 (1st Cir.1994) (giving language in an ERISA-regulated insurance policy its "natural meaning"). In applying this plain meaning analysis, we "must give effect to the unambiguous terms of an ERISA plan." *Lake v. Metropolitan Life Ins. Co.*, 73 F.3d 1372, 1379 (6th Cir.1996).

VI. STANDARD OF REVIEW

As an initial matter, this Court must determine whether to apply a *de novo* or an arbitrary and capricious standard of review to Hartford's interpretation of the offset provision of the plan. In this case the 1990 plan specifically provides:

> The Hartford has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy.

It is well-settled that "a denial of benefits challenged under [ERISA] § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority. . . . " *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *Perez v. Aetna Life Insurance Co.*, 150 F.3d 550, 552 (6th Cir. 1998).

Therefore, because this benefit plan clearly grants discretionary authority to the plan administrator to interpret all the terms and provisions of the policy, the decision of the plan administrator in regard to the provision which provides for an offset of Social Security Disability is entitled to a deferential review using an arbitrary and capricious standard.

Accordingly, Hartford's interpretation of the Plan, resulting in the denial of benefits, must be affirmed unless it is arbitrary and capricious. The arbitrary and capricious standard is explained by the Court in *Shelby County Health Care Corp. v. Southern Council of Industrial Workers Health and Welfare Trust Fund*, 203 F.3d 926, 933-934 (6th Cir. 2000):

> Under this standard of review, "we must decide whether the plan administrator's decision was 'rational in light of the plan's provisions.'" Id. (quoting *Daniel v. Eaton Corp.*, 839 F.2d 263, 267 (6th Cir.), cert. denied, 488 U.S. 826, 109 S. Ct. 76, 102 L.Ed.2d 52 (1988)). A decision is not arbitrary and capricious if it is based on a reasonable interpretation of the plan. See *Johnson v. Eaton Corp.*, 970, 934 F.2d 1569, 1574 (6th Cir.1992).

Based upon the Court's review of the plan and the administrative record in this case, the Court finds that the plan administrator's decision was rational in light of the

plan's provisions. Because the plan administrator's decision was based on a reasonable interpretation of the plan, the plan administrator's decision that Social Security Disability is an offset in regard to the long-term disability payments of the plaintiffs, James Garst, Charles Meridieth, and Donna Russell, is not arbitrary and capricious and the defendants' motion for summary judgment in regard to these plaintiffs will be granted.

Plaintiff Lane

In regard to the plaintiff Donna Lane, there is no evidence in the administrative record that would show that she was approved for Social Security Disability, or that the offset was applied in her case. Her administrative record indicates that the last medical record received by Hartford from her treating physician indicated that she could return to work with no restrictions on November 1, 1997. After her long-term disability benefits were terminated based upon this medical finding, there is nothing in the administrative record to show that she filed an administrative appeal in regard to this termination of her benefits.

It is well settled that a participant or beneficiary must exhaust his or her administrative remedies prior to commencing suit in federal court. See *Baxter v. C.A. Muer Corp.*, 941 F.2d 451, 453-54 (6th Cir.1991). Therefore, the defendants' motions for summary judgment will be granted in regard to this plaintiff based upon her failure to exhaust her administrative remedies.

An appropriate order shall issue.

ENTER:

/s/ Thomas Gray Hull
THOMAS GRAY HULL
UNITED STATES
DISTRICT JUDGE